ANNUAL UTILIZATION REPORT OF SPECIALTY CLINICS-2004

Surgical, Chronic Dialysis, Rehabilitation, Psychology, ABC Clinics

1. Facility DBA (Doing Business As) Name:			2. OSHPD Facility No.:
3. Street Address:	4. City:		5. Zip Code:
6. Facility Phone No.: ( )	7. Administrator Name:		8. Administrator's E-Mail Address:
9. Was this clinic in operation at any time during the year? Yes ☐ No ☐	Dates of Operation (MMDDYYYY) 10. From:	11. Through:	
12. Name of Parent Corporation:			
13. Corporate Business Address:	14. City:	15. State	16. Zip Code:
17. Person Completing Report	18. Phone No. ( ) Ext.		
19. Fax No. ( )	20. E-mail Address:		

CERTIFICATION

I declare the following under penalty of perjury: that I am the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility; that the records and logs are true and correct to the best of my knowledge and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Date

Administrator Signature

Administrator Name (Please Print)

Completion of the "Annual Utilization Report of Clinics" is required by Section 127285 and Section 1216 of the Health and Safety Code. Failure to complete and file this report by February 15 may result in suspension of the clinic's license.

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
818 K Street, Room 400
Sacramento, CA 95814

Phone: (916) 323-7685
FAX: (916) 322-1442

Section 2

OSHPD FACILITY ID No. _____

LICENSE CATEGORY (TYPE) (Completed by OSHPD)

Line No.	License Type	(1)
1	Alternate Birthing Center (ABC)	2
	Psychology	16
	Surgical	20
	Dialysis	4
	Rehabilitation	17

LICENSEE TYPE OF CONTROL

Line No.		(1)
5	From the list below, select the ONE category that best describes the licensee type of control of your clinic. (There will be a drop down box in ALIRTS - see list of choices below.)	

LICENSEE TYPE OF CONTROL CHOICES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (inc. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

Section 3

OSHPD FACILITY ID No. _____

PATIENTS AND ENCOUNTERS IN THE CALENDAR YEAR (ALL CLINICS)

Please report the total number of individual, unduplicated patients served and the total number of encounters for these patients. Please refer to the INSTRUCTIONS for further details.

Line No.		Unduplicated Patients (1)	Encounters (2)
1	TOTAL, all locations under this license (Main, Mobile, Satellite, etc.)		

SURGICAL CLINICS ONLY

Line No.		Number (1)
5	Number of surgical operating rooms on December 31	
6	Total number of surgical operations performed during the calendar year	

PSYCHOLOGY CLINICS ONLY

Line No.	Service Type	Encounters (1)
11	General Medical	
12	Substance Abuse (alcohol and drug)	
13	Mental Health Counseling	
14	All Other	
15	Total	

Section 4

OSHPD FACILITY ID No. _____

INCOME STATEMENT

Line No.		(1) Total
1	**GROSS PATIENT REVENUE**	
	WRITE-OFFS AND ADJUSTMENTS:	
2	Charity	
3	Contractual Adjustments	
4	Bad Debts	
8	Other Adjustments	
9	TOTAL WRITE-OFFS AND ADJUSTMENTS (lines 2-8)	
10	NET PATIENT REVENUE (line 1 minus line 9)	
	OTHER OPERATING REVENUE:	
11	Grants - Public	
12	Grants - Private	
13	Donations / Contributions	
19	Other	
20	TOTAL OTHER OPERATING REVENUE (sum lines 11-19)	
25	TOTAL OPERATING REVENUE (line 10 + line 20)	
	OPERATING EXPENSES:	
30	Salaries, Wages and Employee Benefits	
31	Contract Services - Professional	
32	Supplies	
33	Rent / Depreciation / Mortgage Interest	
34	Utilities	
35	Professional Liability Insurance	
36	Other Insurance	
44	All Other Expenses	
45	TOTAL OPERATING EXPENSES (sum lines 30-44)	
50	NET FROM OPERATIONS (line 25 minus line 45)	

THE CLINIC'S LICENSE FEE WILL BE BASED UPON THE COMPLETION OF THIS INCOME STATEMENT AND WILL BE CALCULATED ACCORDINGLY.

MAJOR CAPITAL EXPENDITURES

Section 5

OSHPD FACILITY ID NO. _____

Section 127285 (3) of the Health and Safety Code requires each clinic to report "acquistions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000)."

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT ACQUIRED DURING THE REPORT PERIOD

Line No.		(1)
1	Did your clinic acquire any diagnostic or therapeutic equipment that had a value in excess of $500,000? (If 'Yes' , fill out lines 2 through 11, as necessary, below.)	Yes ☐ No ☐

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DETAIL

Line No.	(1) Description of Equipment	(2) Value	(3) Date of Acquisition (MM/DD/YYYY)	(4) Means of Acquisition (Check one)			
2				Purchase ☐	Lease ☐	Donation ☐	Other ☐
3				Purchase ☐	Lease ☐	Donation ☐	Other ☐
4				Purchase ☐	Lease ☐	Donation ☐	Other ☐
5				Purchase ☐	Lease ☐	Donation ☐	Other ☐
6				Purchase ☐	Lease ☐	Donation ☐	Other ☐
7				Purchase ☐	Lease ☐	Donation ☐	Other ☐
8				Purchase ☐	Lease ☐	Donation ☐	Other ☐
9				Purchase ☐	Lease ☐	Donation ☐	Other ☐
10				Purchase ☐	Lease ☐	Donation ☐	Other ☐
11				Purchase ☐	Lease ☐	Donation ☐	Other ☐

BUILDING PROJECTS COMMENCED DURING REPORT PERIOD COSTING OVER $1,000,000

Section 127285 (4) of the Health and Safety Code requires each clinic to report the "commencement of projects during the reporting period that require a capital expenditure for the clinic in excess of one million dollars ($1,000.000)."

Line No.		(1)
25	Did your clinic commence any building projects during the report period which will require an aggregate capital expenditure exceeding $1,000,000? (If 'Yes', fill out lines 26 through 30, as necessary, below.)	Yes ☐ No ☐

DETAIL OF CAPITAL EXPENDITURES

Line No.	(1) Description of Project	(2) Projected Total Capital Expenditure	(3) OSHPD Project No. (if applicable)
26			
27			
28			
29			
30			